Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7601	A. BUILDING: _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTSVILLE MANOR	287 BAKER STREET HUNTSVILLE, TN 37756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the annual Licensure survey and complaint investigations (#32220, #32378) conducted on October 30, 2013, at Huntsville Manor, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000	**Monitoring of corrective action to ensure the deficient practice will not recur;** 4. DON will assure compliance by weekly review of dental log to ensure residents have had a yearly routine dental and/or emergency dental care as needed for 4 weeks in accordance with facility policy. Overall findings will be reported to NHA immediately. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of DON, Medical Director, ADON, NHA, Risk Manager, MDSC, Pharmacy Consultant, Registered Dietician, Wound Care Nurse, SSD) to review the need for continued intervention or amendment of plan. 5. Completion date:	11/15/13

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Williams 6899 — TITLE: Administrator — (X6) DATE: 11-12-13